INDUSTRIAL MEDICAL COUNCIL

Medically Speaking

P O BOX 8888 San Francisco, CA 94128 January 1998 Vol. 3 No. 1

IMC Conference Treats Physicians To Diverse Views

The Industrial Medical Council held what some suggested should be the first of its annual educational conferences for treating physicians on November 20. The conference, attended by nearly 300 physicians and distinguished guests, was aimed at treating physicians who have been integrated into the compensation system at the report writing level.

"I think on balance, we succeeded in getting a great deal of information conveyed to physicians," said Dr. D.A. MacKenzie, Executive Medical Director. "We went into this venture with an open mind because we really didn't know what kinds of questions or concerns to expect, but we certainly do now."

The day's presentations were organized into distinct segments. The first segment -*Workers' Compensation Fundamentals***,** dealt with the basic essentials of a workers' comp practice. David Kizer, Esq. was the kick-off speaker and provided an excellent introduction to the field of Workers' Compensation, including laws and regulations. He touched on the legal and medical responsibilities of the primary treating physician as well as the QME process. Dr. Phil Wagner of Eureka expanded on the *Primary Treating Physician's Responsibilities* and Dr. Gideon Letz (State Fund) added commentary. Dr. Wagner and Dr. Letz offered examples of how the treater's role is important both to the worker's benefits and the overall efficiency of the delivery system.

Dr. Theodore Blatt gave an incisive presentation on *Final Disability Report Writing,* including a solid approach to some of the difficulties of analyzing subjective complaints and Suzanne Marria, Esq. added an appropriate commentary.

The second segment dealt with *Case Management Issues*. Dr. Tom Herington's presentation on *Delayed Recovery/Disability Management* was one of the highlights of the day. This was followed by Dr. Linda Rudolph's presentation on the *Utilization Review Regulations.* Dr. Robert Amster then followed with an insurance perspective on *UR/Case Management.* Dr. Wagner presented his thesis that to survive in the California Workers' Comp Community, one must utilize Practice Management Software. He proceeded to offer ideas on how this could be accomplished.

Drs. Gayle Walsh and MacKenzie jointly presented an overview of the *IMC Treatment Guidelines* and Dr. Alicia Abels spoke to the issue of *Appropriate Physical Medicine Referrals* and gave a physical medicine update.

The final segment dealt with *Caveats for Report Writing.* The Honorable Mark Kahn addressed the complicated issues of *Causation and Apportionment* and Dr. Glenn Repko discussed the importance of *Sensitizing the Treating Physician to Psychosocial Issues*. Dr. Robert Larsen spoke on appropriate psychiatric referrals.

IMC staff expended a great deal of planning and hard work on this venture and hope that all participants realized the benefits of these efforts. Dr. MacKenzie said that the importance of the conference lies in the fact that many of the physicians in the compensation community are unfamiliar with the rules and terminology required to practice effectively.

"Even the grizzled veterans have a hard time keeping up," he said. "This kind of outreach is the IMC's way of giving physicians a forum of their own to discuss and debate the issues."

Dr. Walsh, who spoke on the IMC treatment guidelines said she had the

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IMC goes digital; Web site on-line

The IMC is pleased to announce that its new web site is now on-line. The site--**www.dir.ca.gov.** takes the viewer to the Department of Industrial Relations web page where Workers' Compensation may be selected from the directory and then the Industrial Medical Council can be hypertexted.

The IMC web site currently includes relevant phone numbers and forms, a set of commonly asked questions about QMEs and the QME process, treatment and evaluation guidelines, all editions of *Medically Speaking,* and a lot more. Dr. Anne Searcy, who has been working on the site over the past several months, said it will incorporate more information as it becomes available, including the second edition of the *Physicians' Guide.*

IMC Sends Fee Recommendations to AD

By Susan McKenzie, MD

On November 24 in San Francisco and November 25 in Los Angeles, the Division of Workers' Compensation (DWC) held hearings on controversial proposed changes to the Official Medical Fee Schedule (OMFS), Medical-Legal Fee Schedule (MLFS), Hospital Fee Schedule, utilization regulations, and reporting responsibilities of the primary treating physician.

Members of the workers' compensation community presented testimony to Casey Young, Administrative Director of DWC, under whose authority the fee schedules are promulgated.

The hearings represent the final stage in the lengthy process by which the fee schedules are revised biennially. The IMC played an important role in making recommendations for both the OMFS, which sets maximum reasonable fees for medical treatment, and the MLFS, which sets reasonable fees for medical-legal evaluations and testimony.

Background

The process of revision began in June, 1996, when the IMC and DWC jointly convened a series of public meetings to develop consensus recommendations for changes to the existing fee schedules. The meetings were open

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EMD Viewpoint

By : D. A. MacKenzie, MD, FAAOS

With the successful completion of the IMC Treatment Guidelines, the IMC's stellar work in facilitating the Fee Schedule Task Force, and the excellent Education Conference this November, we bring to a close perhaps the most significant year of accomplishment in the IMC's eight year existence.

I know there are many who have doubted whether we could actually gain enough consensus from the employer, employee, physician and insurance community to pull off some of the more contentious legislative tasks we are given, but I believe our commitment to working closely with the community and keeping the lines of communication to all parties open at all times has been the key to our success this year.

Probably the most significant achievement was the adoption of the treatment guidelines. In earlier **viewpoints**, I have shared my feelings with you on this difficult task. An assault on Everest should be this easy.

But the year 1997 brought us other bounties of success. We are quite proud of the CQI touch-ups on the cardiac and pulmonary forensic guidelines and our second edition of the *Physician's Guide.* We have amended our QME forms, and streamlined our QME application and reappointment process, conducted a customer satisfaction survey for QMEs, and made our 800 number as user friendly as possible. We are also updating our chiropractic certification program and CME course audit protocol. We will continue to work on our new web site and our QME report review. The check-off list for the coming year has already begun as we begin charting the *Continuous Quality Improvement* phase of the treatment guidelines. Expect to hear much more on this in the coming months.

Although the beginning of my tenure as EMD was marked with a "crisis of the week," as I began to meet and confer with members from the WC community and the legislature, I was struck by the fact that many people simply wanted a voice in a process that has grown very large and cumbersome over the years. I have tried to assure everyone who deals with the IMC that, wherever possible, we will give them that voice, and more importantly, that it will be heard.

More good news. We are recently advised by Cooperative Personnel Services that they will continue to administer the QME Exam! The Department of General Services had questioned the State's various agencies about administering their own exams. The agencies (IMC included) were in support of CPS since the costs in test development and resources required to administer the exam are quite prohibitive in this era of streamlined budgets. We believe CPS has done a superb job.

We hope that you enjoy this edition of our Newsletter. We put a lot of time and energy into making it useful for everyone in the Workers' Compensation community. This edition introduces a new feature *Community Viewpoint* to allow QMEs and our readers an opportunity to share their thoughts on issues germane to workers' compensation. As a public agency, we feel this is an excellent way to receive public comment on areas of concern. If you have an idea you'd like to share (or just stimulate some dialogue) pass along your thoughts.

Finally, I would like to offer a vote of thanks to the IMC staff. Any State agency would be lucky to have such people.

Special thanks to Teidi Lee-Padua for her hard work on the conference.

Looking ahead, we are hoping to continue the success we have enjoyed this year. As always, I thank you for your continued support and encouragement. Drop me a line and let me know how you think we're doing.

IMC staff and I extend best wishes for this coming new year!

Council Members List

ABELS, ALICIA MD
3581 Palmer Dr., #501
Cameron Park, CA 95682
(916) 676-8441 FAX (916) 677-5394

MONOSSON, IRA H. MD
9025 Wilshire Blvd., Ste. 400
Beverly Hills, CA 90211
(310) 786-8385 FAX (310) 786-8384

TAIN, LAWRENCE DC
8950 Villa La Jolla Drive, Ste. 1220
La Jolla, CA 92037
(619) 457-3700 FAX (619) 450-1922

AMSTER, ROBERT, MD
3070 Bristol Street, 3rd Floor
Costa Mesa, CA 92626
(714) 429-2584 FAX (714) 429-2645

NAGELBERG, STEVEN MD
4955 Van Nuys Blvd. Ste. 520
Sherman Oaks, CA 91403
(818) 906-2456

REPKO, GLENN R. PhD
450 North Bedford Drive, #302
Beverly Hills, CA 90210
(310) 274-2735 FAX: (310) 273-0580

COHN, REBECCA W. PT
14510 Big Basin Way, Ste. 236
Saratoga, CA 95070
(408) 867-4284 FAX (408) 867-4493

NG, JONATHAN T. MD
1835 Park Avenue
San Jose, CA 95126
(408) 295-0514 FAX (408) 295-9844

WALSH, GAYLE A. DC
630 Fountain Avenue
Pacific Grove, CA 93950
(408) 373-1003 FAX (408) 373-1024

GOLDBERG, ROBERT L. MD
1524 McHenry Avenue, #520
Modesto, CA 95350
(209) 575-5801 FAX (209) 575-0115

PITTS, RICHARD DO
1045 North Tustin Avenue
Orange, CA 92667
(714) 997-5865 FAX (714) 744-1991

WOLL, LAURIE DO
9369 Central Avenue
Montclair, CA 91763
(909) 621-5005 FAX (909) 621-4900

LARSEN, ROBERT C. MD
690 Market St., #706
San Francisco, CA 94104
(650) 391-3434 FAX (650) 391-3436

ROBACK, MICHAEL D. MD
5901 W. Olympic Blvd., #401
Los Angeles, CA 90036
(213) 938-4131 FAX (213) 938-1045

LIPTON, MARVIN H. MD
1663 Rollins Road
Burlingame, CA 94010
(650) 692-2663 FAX (650) 692-2777

SOMMER, RICHARD F. ESQ
1197 East Arques Ave.
Sunnyvale, CA 94086
(408) 957-5703 FAX (650) 753-1293

Newsletter Staff

Editor : David A. Kizer, Esq.

Writers: Anne Searcy, MD
Susan McKenzie, MD
Helen Rockwell, WCC

Layout & Design: Lety Buenviaje

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Community Viewpoint

MINNIEAR -- THE CHALLENGE AND THE PROMISE

By: Shawn King, Esq.
Newton Medical Group

One of the more far reaching changes which has reshaped the workers' compensation landscape in recent years has been the growing authority and reliance placed with and upon the treating physician. This goes beyond the seemingly endless barrage of forms that treating physicians are now expected to complete on a regular basis. The central power of the treating physician in the workers' compensation system is summed up succinctly in **Labor Code §4062.9.**

"In cases where an additional comprehensive medical evaluation is obtained under §4061 or 4062, the findings of the treating physician are presumed to be correct. This presumption is rebuttable and may be controverted by a preponderance of medical opinion indicating a different level of impairment. However, this presumption shall not apply where both parties select qualified medical examiners."

What the statute basically comes down to is this--in any dispute with the treating physician, a QME report with an opinion different from that of the treater will not be used as the basis for judges decision unless the treater's report is grossly deficient or unless the QME simply overwhelms the logic offered by the treater in favor of the treater's conclusions.

Why then the excitement over the *Minniear* decision? Doesn't the statute clearly enunciate the burden of going against the treating physician's opinion? Well, yes and no.

Traditionally, lawyers rely upon two signposts to guide them in their practice --statutes and case law. But like longitude and latitude, having only one doesn't tell the whole story of what your location is at any given moment. One needs both elements to truly feel comfortable in reporting a location.

Until the *Minniear* decision, lawyers had to pretty much rely on the statute alone. *Minniear* provides lawyers a crucial reference point. The powers that be, (i.e., the workers' compensation commissioners,) have now given lawyers a blueprint to follow in gauging whether or not the presumption afforded the treating physician by Labor Code §4062.9 is rebuttable given the fact pattern of any particular claim.

Three elements have been brought into clearer focus. First, the commissioners deciding the *Minniear* case point to the specific language of §4062.9 and its reliance upon **medical** opinion as meaning that mere history from a layperson will not overcome the conclusion in the treating physician's report. In other words, if you get different history from an injured worker and use that as the sole basis to distinguish your conclusions from that of the treater, you have not done enough. The history you used was merely that of a layperson. Stronger medical rationale is necessary to cast aside the opinion of the treater.

Those doctors that write in a conclusionary style, well, they might as well stop writing now. Conclusions are not enough to defeat the presumption afforded the treating physician.

Second, chronologically reporting after the treater doesn't make a QME report better either. Although some cases have found reports and reasoning in these reports "stale" if too distant in time to the awards process, the mere fact that a physician might see the injured worker at a later date than the treater does not guarantee that the later report or opinion(s) will carry the day.

Third, despite the fact that treating physicians have somewhat of reputation for being less sophisticated than QMEs in the addressing of medical legal issues, your credentials as a QME are insufficient to rebut the treater without significantly more effort.

To overcome the presumption, you must specifically state the area of your disagreement and then provide a point by point, medically superior argument as to why your opinion is more reliable than that of the treating physician.

Since awakening from its deep sleep, Labor Code §4062.9, the treating physician's presumption of correctness, continues to take shape. One of the more recent cases is *Teledyne Ryan Aeronautical v. WCAB (Ausen) (1997) 62 CCC 832.* In this case, the applicant sustained a repetitive injury to his upper extremities. The applicant relied on the report of the QME, finding 22 1/2%, while defendant relied on the final reports of the treating physician, which rated 8%. The WCJ relied on the QME's report and found permanent disability of 22 1/2%. Defendants sought reconsideration.

The WCJ found that the applicant's testimony (lay witness) more clearly matched the QME's report of limitations and modifications than did the treating physician's report. The Court of Appeal found that the WCAB did not base its decision on the testimony of the lay witness, but rather using the report of the QME and applicant's testimony found the two to be consistent, while the report of the treating physician was inconsistent.

The Court of Appeal concluded:

"The Board did not rely on merely the chronology of the reports. Rather, it accepted a later report that demonstrated a more thorough evaluation based on more comprehensive information, as well as deterioration in the applicant's conditions since the report of the treating physician".

The Petition for Writ of Review to the Supreme Court was denied.

That then is the challenge of *Minniear*. The promise of *Minniear* is found simply by contemplating how often it is that one side to a workers' compensation claim will dispute the treating physician. Any time one side or the other "likes" what the treater has said, that side will seek to rely upon the treating physician's opinion to settle the matter. Knowing that the doctor they select must author a clearly superior report, the party disputing the treater's report is going to search increasingly more for a doctor who can demonstrate the ability to provide analytical reasoning in his/her report. We are likely to see an even further constriction of the QME pool.

Those doctors that write in a conclusionary style, well, they might as well stop writing now. Conclusions are not enough to defeat the presumption afforded the treating physician. Only solid, well reasoned and clearly written medical reports will suffice. If you can provide such reports, *Minniear* likely represents the best thing to happen to your forensic practice in quite some time.

By the by, the citation for the *Minniear* case is 61 CCC 1055.

(We thank Mr. King for sharing his views.)

CONFERENCE Q & A

We received a large number of questions at the November Educational conference which we were unable to answer due to time constrains. The following are questions submitted to presenters for their response. Please note the answers are not those of the IMC and express the presenter's point of view on a given area. The answers are not intended to serve as legal advice.

Phillip Wagner, MD, MRO

Q: With your information flow, how do you protect confidentiality?

A: In our office, we use a computerized information system connecting the employer, the carrier and the provider. The information transmitted across that system is limited to dates of service, work status, activity level, and CPTs representing various procedures which have been utilized. This information is maintained on a central server which requires an entry code for each entity requesting information. That entity's entry code allows them to see only cases which pertain to their business.

Where the carrier requests a progress note to review doctor's comments, we provide those following the guidelines set by the American College of Occupational Medicine regarding psychiatric, substance abuse, and AIDS issues.

Q: Why has there been no increase in reimbursement even though the workload of the treating physician has increased tremendously?

A: This is basically a market issue. Until the reforms of 1994, quality of care was not particularly important as a driver in this system. Therefore, in the marketplace there were sufficient number of physicians willing to accept the unchanged reimbursement so that no changes needed to be made.

Following the reforms of 1994, the Administrative Director and Industrial Medical Council wisely put quality management of this system back in the medical arena. Quality is an issue of equal importance with cost. It is essential that treating physicians with a thorough knowledge of workers' compensation and who treat their patients with sound medical practice be paid fairly for their efforts.. I would advise primary care physicians, however, that this will be a very competitive market and they will be required to demonstrate their skills in an objective fashion to purchasers of service.

Q: Insurance companies pay $250.00 for a primary treating physician's report. For $250.00, how much information is essential?

A: The primary treating physician's permanent and stationary report is the foundation for cost savings and equitable and timely resolution of cases. In my opinion, this is not a medical legal report when it is generated. A medical legal report only occurs when there is a disputed issue in the case, and I don't believe there can be a dispute without the primary treater's report being available to review. Therefore, the primary treater's report is billed through the Official Medical Fee Schedule. Despite multiple meetings between carriers and providers, there has been no consistent formula developed for charges on this report. In my office, the primary treater's permanent and stationary report is comprehensive including all elements as required by the code. Notes are available in my section of the syllabus on Responsibilities of the Primary Treating Physician. Those are also available through Dr. Ted Blatt's presentation. In my office my method of charging for these services is to charge a level 5 Medical Consultation fee plus a special report fee for each page generated to a maximum of 6 plus a charge for non face-to-face time required to review

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Council Amends Policy on Thermography

The IMC has adopted a new policy with respect to the use of thermography in the diagnosis of certain conditions under workers' comp.

The policy statement was adopted at the October 16th IMC Council meeting after concerns were expressed by some council members that the existing policy adopted in 1994 was not reflective of current practices in the community.

The new policy is as follows:

❖ Thermography for the diagnosis or prognosis of most neuromusculoskeletal conditions cannot be scientifically justified at this time.

❖ Although the scientific efficacy has not been proved, thermography may be useful as an adjunctive test in the diagnosis of:

A. Reflex Sympathetic Dystrophy
B. Vasospastic conditions such as Raynaud's Phenomenon and Disease

❖ Anyone performing or interpreting thermography testing shall be certified by and adhere to the protocols established by one of the following:

A. American Academy of Medical Infrared Imaging
B. America Academy of Thermography
C. American Chiropractic College of Thermography (American Chiropractic Association)

❖ The only acceptable Thermographic testing medium is Infrared Imaging. Contact or Thermocouple Thermography is not acceptable.

The IMC policy is not a regulation and therefore not binding on the public. It is solely an expression of opinion of IMC Council Members on this particular form of diagnostic methodology.

A decision will be made as to how the new policy might be integrated into the IMC Treatment Guidelines as they are amended in future public hearings.

✦ **cont'd from p.1--Conference**

opportunity to speak with physicians about some of the frustration they have felt over keeping up with the laws and paperwork in treating and evaluating their patients.

"We will meet and discuss the results and feedback of the conference and hopefully develop some ideas on how to better accomplish this," she said.

Conference On Audio Available to Physicians

The IMC is offering a complete set of audio tapes of the recent Educational Conference for Physicians to those interested in puchasing them for home or office use. The tapes cover the full conference.
The price is $25.00 and it includes a copy of the syllabus.
Call 1-800-794-6900 to order.

✦ cont'd from p. 4--Q &A

medical records and formulate opinions. That code is 99358 in the Official Medical Fee Schedule. The sum of all of these charges amounts to between $300.00 and $400.00.

Q: What do you do with a patient who has an injured extremity that could work light duty, but can't drive to work?

A: I put them at light duty status appropriate to their current level of impairment. How they get back and forth to work is a matter to be resolved between them and their employer, as it is not a medical issue.

Q: Treating objective findings when the subjective outweighs objective. Objective findings are still objective findings, and need treatment despite over-exaggeration of subjective.

A: An individual's responses to impairment and injury vary over a wide range. The key factor in treating these injured workers is to restore maximum function and restore it as soon as possible. Thus, I do not treat subjective or objective factors, but I treat the patient.

Q: Why is there no doctor-patient confidentiality in workers' compensation?

A: I would refer you to the American College of Occupational Medicine's ethical guidelines on confidentiality. Formerly, Workers' Compensation medical treatment was an open book with the following exceptions:

1. **Psychiatric issues**
2. **Substance abuse issues**
3. **Issues surrounding AIDS**

The legislature also recently enacted Labor Code § 138.7 which provides stronger privacy protection.

Q: Should you request a job analysis before writing a final report (please note that many job descriptions are incomplete or inaccurate)?

A: If you are not satisfied that you have a clear understanding of what this individual does at their workplace, I would strongly recommend that a job analysis be obtained prior to writing the final report. This job analysis should be signed off by both the employer and the employee so that it reflects an appropriate estimate of this person's job duties.

Q: How do you handle adjustors who direct the transfer of care to an orthopedist as the primary treater even if the patient seems satisfied with the progress under your care?

A: Under the Labor Code, adjustors may not change a worker's PTP after the first 30 days. After the first 30 days, and where the worker has medical control, only the worker or their representative has the right to make that change with the exception of the case where the employer and/or carrier files a petition to change treating physicians based on lack of reporting or gross evidence of incompetence in treatment.

Thus, when your patient or the adjustor indicates that they have designated a different physician as the treating physician, the appropriate response is to ask the patient who they wish to designate as their primary treating physician. If they wish to continue with your services as a primary treating physician, they need to submit in writing to the carrier a letter to that effect. Once notification has been made, you are the primary treating physician on the case and may proceed appropriately.

Q: What do you do with employees injured where no light duty provisions are available?

A: This places the injured worker at extreme risk for delayed recovery and long term loss of function. In these cases, I make every effort to contact the decision-making person or body at the company and present the issues regarding delayed recovery. I also contact the insurance company who is handling claims for that company and they are usually most helpful in attempting to establish a limited duty program. Where that is not possible, I enroll the employee in an independent exercise program which keeps them active on a daily basis while they are waiting for sufficient recovery to return to work.

Q:. How extensive should progress reports be?

A: With the reforms of 1994, the treating physician's scope of practice has expanded significantly. Their responsibilities for management of the case are extensive and efforts at meeting those responsibilities need be appropriately documented in order to apply the appropriate E & M Code. Therefore, I recommend that primary treating physicians include all the essential factors required by the Official Medical Fee Schedule for the specific E & M level which they are charging.

I have developed a series of dictation templates which call for each of the categories required to be commented on in each progress note for a specific level. In that way, there is no confusion regarding what time was spent or what thought process was applied in making decisions regarding this patient's care. The carriers find this most helpful in understanding all those facts surrounding the case. There is slightly more time involved in performing this process, but in the long run it results in a more rapid return to function and a decrease in unnecessary fee disputes.

Q: Can a doctor's first report be used as a treatment plan?

A: It is possible for a first report to be utilized as a treatment plan if all essential factors are included within that report. From a practical standpoint, this presents an untenable position for the treating physician as the treatment plan must be designed to extend through the expected length and course of the case.

In my office, the First Report of Injury is generated by a computerized information program that is drawn directly off of my charge sheet. It is generated on the same day of contact and submitted on that date. Items 17-23 are filled out in very brief descriptive terms which is sufficient for meeting first report requirements. A dictated progress note is done on the same date, but it is not necessary to submit that progress note along with the first report to meet legal requirements.

We use prospective protocols which outline treatment plans for various conditions which we see in our practice. Those treatment plans are no more than one page long and designate expected treatment and outcome for each phase of treatment. A copy of that protocol is submitted with the first report and acts as a treatment plan, meeting the appropriate legal requirements. We also submit a copy of that protocol to the employer if they wish to see it, and to the injured worker if they wish to see what their expected treatment is. It is our opinion that the best scenario is to have all parties to this injury as well informed as possible.

Ted Blatt, MD

Q: Can a patient be classified in occasional severe pain and intermittent slight pain at the same time?

A: Yes, clinical symptoms may increase upon performing certain activities (e.g. pain may increase to severe upon heavy lifting).

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✦ cont'd from p.1-Fee recommendations

to all members of the workers' compensation community and were hosted both in northern and southern California by the IMC. Between forty and sixty medical providers, insurers, third party administrators, bill review company representatives, and other interested parties attended each of the meetings.

Two independent Task Forces were formed - one to propose revisions to the OMFS ground rules and one to consider revisions to the MLFS. The Task Forces were advised by Mr. Young that all issues pertaining to the fee schedules were "on the table" and that each Task Force could set its own priorities. Numerous subcommittees were formed to discuss issues in depth and to report recommendations back to the full Task Force for consensus votes. Task Force participants collectively spent thousands of hours in meetings to resolve issues of concern; and to those individuals and the organizations who supported them, we express our appreciation.

Over the next nine months, major proposals emerged from this consensus driven process. The OMFS Task Force recommended updating the 1994 AMA CPT coding schema and ground rules in the existing OMFS to the 1997 CPT. The decision was made to retain the current relative value scale (RVS), while incorporating values only for new, significantly changed, and newly valued codes from a proprietary RVS developed by Medicode, Inc., the vendor who last updated the relative value scale. The Task Force agreed to consider adoption of a revalued RVS, such as the RBRVS, for the year 2000 revision.

Recommendations on ground rules

The OMFS Task Force worked to clarify language in the ground rules. Among its many significant recommendations were:

(1) requiring payer confirmation (in writing or with a confirmation number) of verbal authorization for medical services which require prior authorization or for which the provider voluntarily seeks confirmation;

(2) establishing reimbursement formulae for dispensed durable medical equipment and for several supplies and materials which the Task Force disembedded from procedure codes;

(3) disembedding vaccines from immunization codes for which the cost of the vaccine currently exceeds the RV;

(4) changing from a 30 to a 15 minute time basis for reimbursement for non face-to-face prolonged services such as reviewing job analyses and work limitations;

(5) reimbursing for chart notes and for duplication of medical reports, X-rays and scans;

(6) adding a multiplier of 1.1 for examinations requiring an interpreter;

(7) establishing a formula for reimbursement for the primary treating physician's permanent and stationary report; and

(8) making significant changes to the format and substance of the PM&R section, including deletion of the "2.4 reduction" and a change in the types of treatments permitted without prior authorization.

The MLFS Task Force made several important recommendations for changes to the language of the medical-legal fee schedule: (1) addition of an ML 100 code with reimbursement for missed appointments; (2) restructuring of reimbursement for ML 101 evaluations from a $250 flat fee to $50 per 15 minutes for evaluations done within nine months of the prior evaluation; (3) provision for combining the time-based complexity factors to ease qualification for an ML 103 or ML 104; (4) addition of a complexity factor for psychiatric and psychological evaluations which are the primary focus of a med-legal evaluation; and (5) clarification of the language regarding when a modifier - 93 is to be used.

In addition, the MLFS Task Force formed a subcommittee to reconsider the "Newton" medical-legal complexity scale first introduced in 1993. No consensus was achieved on adoption of that schedule as it was felt there was insufficient agreement on its parameters and inadequate time to evaluate the potential impact of its implementation. The Task Force voted to form a subcommittee to reconsider the complexity scale at the next fee schedule revision.

Some issues lack consensus

As might be expected, it was not possible for the Task Forces to achieve consensus on all issues - namely, changes to the conversion factors for both schedules; use of a wider range of E/M codes by and reimbursement for nurse practitioners and physicians assistants; and assignment of relative values for the new CPT codes for chiropractic manipulation.

In March, payers and providers developed position papers on these issues; and those papers, along with the recommendations of the Task Forces and a Medicode benchmarking study supporting an increase in OMFS conversion factors, were forwarded to Mr. Young.

The text of DWC's proposed fee schedules was released in October, following an earlier announcement in which Mr. Young indicated that he intended to raise only the E/M conversion factor. Most of the recommendations of the OMFS Task Force were included in the proposed schedule with the exception of " confirmation of verbal authorization" (the concept was retained but the language was moved to the UR regulations) and reimbursement for the primary treating physician's report (changed and made part of a lengthier "reports section" which provides for reimbursement for a new series of mandatory treating physician reports). For the MLFS, reimbursement for the newly created "missed appointment" code (ML 100) was changed to "By Report", but the other recommendations of the MLFS Task Force remained unchanged.

On the unresolved, but critical issue of conversion factors, Mr. Young proposed that the conversion factor for E/M services be raised from $7.15 to $8.50 to compensate for the increased management and reporting requirements in workers' compensation. No other conversion factor changes were proposed. Full reimbursement for nurse practitioners and physicians assistants using E/M codes within their scope of practice was included, along with the requirement that these practitioners be identified with a modifier.

In addition, Mr. Young added a modifier code for missed appointments and a modifier which would reimburse for psychological services provided by unsupervised non-physicians at 60% of the reimbursement for psychiatrists and psychologists with doctoral degrees.

Contracts were exempted

Relative values were assigned to new and significantly changed codes - with continued controversy centering about the appropriate values for chiropractic and osteopathic manipulation. A relative value of zero was assigned to code 97010 (application of hot or cold packs), thus deleting reimbursement for a leading cost driver. Finally, Mr. Young added a provision to the OMFS which would exempt from the schedule all providers and employers/insurers who have a written contract which fixes the amounts to be paid for medical services. The

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✦ cont'd from p. 5--Q & A

Q: If the patient refuses treatment, can he/she still be a QIW? (i.e., refuses back surgery for fear of complication and therefore cannot perform usual job).

A: Yes, work restrictions are based on current assessment.

(Audience comment) : When addressing return to work and work restrictions--it should mentioned that it's important to note if restrictions are temporary or permanent (which leads to expensive vocational rehab). The treating physician is **key** in this process.

Q: Would diagnostic studies be included with the results of a provocative physical exam test such as a Lachman test?

A: Yes, It would be included in objective factors.

Alicia Abels, MD

Q: We now have insurance carriers (HMOs) with capitated contract with our therapists. Those plans become very upset when we specify treatment. They want the therapist to determine frequency, duration, etc. What should we do about this?

A. In a capitated system, there is risk of underutilization. You, ultimately, as the ordering and treating physician have responsibility for the patient. You are really responsible for what that patient gets as medically necessary treatment. You should be specific in your treatment plan. You should be specific in ordering what your patient needs. If the therapist doesn't agree with you, there should be an open dialogue between you and the therapist because you can be educated and the therapist can be educated (as to the patient's needs).

Gayle Walsh, DC

Q: Does the TX guidelines address weight loss program? I often run into doctors who say "unless the patient loses 100 lbs, i.e., from 240 to 140 she/he would not be P & S?

A: No, the guidelines do not address this issue. The guidelines deal with diagnosis, treatment in the first 90 days. Weight loss may lead to a better outcome, but would come under the aspect of educating the injured worker on how to manage their injury and the expectations they can have for improvement. Otherwise, weight loss would be dealt with under tertiary care.

Q: While there is a large amount of literature and now treatment guidelines on upper extremity, back, and knee injuries, are you in the process of establishing treatment guidelines for foot & ankle since these are being seen at an increasing rate especially with CT claims?

A: At the time the IMC was directed to draft treatment guidelines, the former Executive Medical Director, surveyed for the most common industrial injuries. These conditions resulted on these guidelines. As ankle and foot or other injuries become more prominent, the IMC will draft additional guidelines. At the present time the IMC intends to monitor the use of the current guidelines and the need for continuous quality improvements.

✦ cont'd from p. 6--Fee recommendations

language of this provision, as it is currently written, would authorize contracts which reimburse above or below the fee schedule and would appear to make the fee schedule inapplicable where those contracts exist.

Testimony was restrained

The DWC changes were the primary focus of testimony at the November hearings. Testimony was cautious and restrained, leaving the impression that most comments had been submitted in writing. Both payers and providers requested clarification of the language exempting contracts from the fee schedule; and testimony was taken on conversion factors, relative values, reimbursement of nurse practitioners and physicians assistants, and changes to the physical medicine section. The California Workers' Compensation Institute presented a cost impact study which projected the cost increase of proposed changes in the OMFS to be 11% - as opposed to the 1.7-3.5% increase projected by DWC.

The proposed schedules may be changed by DWC in response to written and oral comments. Changes are usually followed by one or more public comment periods, although DWC has noted that it does not have to comply with the Administrative Procedure Act (formal rulemaking) for fee schedules. It seems reasonable to expect at least one additional public comment period, with implementation in the spring. Copies of the proposed fee schedules may be purchased from Aurora Medina in DWC at (415) 975-0700.

The QME examination will be held on 3/28/98.
The application form will be sent out the first week of January. The cut-off date to submit the application is 2/26/98.
For more information, contact Joanne Van Raam at (650) 737-2004

Continuing Education Providers List

Since the last edition of *Medically Speaking*, the following providers have been approved for continuing education. All QMEs are required to complete 12 hours of continuing education prior to reappointment to a new two year term.

# 660	Blue Cross & Unicare 14442 Riverton Street Westminster, CA 92683 (714) 429-2796
# 670	State Compensation Insurance Fund 1275 Market Street San Francisco, CA 94103 (415) 565-1147
# 680	Mitchell J. Pearce, D.C. MS. Acupuncture, Chiropractic & Nutrition Clinic 100 O' Connor Drive, Ste. 3 San Jose, CA 95128 (408) 293-3883
# 690	American College of Chiropractic Orthopedists 31796 Casino Drive, Ste. B Lake Elsinore, CA 92530 (909) 674-7853
# 700	Landmark Healthcare 1750 Howe Ave., Ste. 400 Sacramento, CA 95825 (916) 569-3347
# 710	Westshore Lien Management 5900 Alpha Circle P. O. Box 430 Pilot Hill, CA 95664 (916) 887-7400
# 720	California Acupuncture Medical Association 12751 Brookshurst Way Garden Grove, CA 92641 (714) 638-2922

RANDOM NOTES

☛ The IMC held its yearly election of officers at the December IMC monthly meeting. The officers for 1998 are: **Dr. Richard Pitts** and **Dr. Steven Nagelberg** *Co-Chairs*; **Mr. Richard Sommer** *Vice-Chair;* **Dr. Glenn Repko**, Secretary.

☛ The IMC Physicians' Guide is in the final stages of revision and should be available soon to the public. Updates include recent revisions to the Labor Code and the IMC regulations as well as new material on report writing and information for office staff. A free copy will be given to all QMEs.

☛ The IMC has released a new fact sheet for injured workers for distribution at physicians' offices and through the Information and Assistance offices around the state. The pamphlet describes various common questions that arise during the QME and examination process and provides information on who to call and where to go. Copies are available free.

IMC Committee reviewing chiropractic certification

The IMC chiropractic advisory committee is currently reviewing the criteria for Workers' Compensation Evaluation. Labor Code section 139.2 requires a Doctor of Chiropractic to have either a certificate in Disability Evaluations (also often referred to as Industrial Disability Evaluation) with an accredited California college or recognized professional association or 300 hours of post graduate specialty education with a school or college recognized by the council.

The committee is looking at various proposals including recommendation that all disability evaluation courses contain a minimum of 36 hours of instruction with the stated goal that minimum standards will be established that will produce physicians who can write readable and ratable reports.

"We want to look at the programs, the consistency and the requirements we have in place," said Dr. Larry Tain. "And we also don't want this to become a competitive thing. We would like the current programs to focus on what will help the IMC approve good evaluators."

The committee will review the current criteria and make a recommendation to the full council on all aspects of the certification approval process.

FAX ON DEMAND

IMC's Fax Information Directory

Telephone # (650)737-2063 or 1(800)794-6900 ext. 2063

Forms and Course information for doctors press 1
Forms for an injured worker press 2
Agendas for IMC's monthly public meetings press 3
For a list of approved and draft guidelines press 4
For IMC's Newsletters press 5
To receive a directory of available faxes press 6
To reach an operator press 0
When calling from outside the 650 area code enter 1 and your area code along with your fax number to receive a fax

DEPARTMENT OF INDUSTRIAL RELATIONS
INDUSTRIAL MEDICAL COUNCIL
PO BOX 8888
SAN FRANCISCO, CA 94128-8888